KINEMEDIC CONCEPTS, INC.

Please mail or Fax completed Credit Card order form to:

P.O. Box 3220 Blue Jay, CA 92317 - Fax (909) 498-0300 - Phone/Fax: (909) 337-3449

*Name on Card:_____

*Billing Address for Card: _____

_____

*****Type of card, (circle): Visa MasterCard American Express Discover

*****Amount to be billed to credit card_____

*****Credit Card # _____ *Security # on back ___ ___ ___

*Security # on front if AMEX ___ ___ ___ ___ *****Expiration Date: _____

*****Name on Credit Card:_____

*****Billing Address for card: _____

*****Signature: _____

***Required field*